MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address Syzygy Associates 2450 Fondren, Ste. 312 Houston, TX 77063	MDR Tracking No.: M4-03-8493-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Texas Mutual Insurance Co. 221 W. 6th St., Ste. 300 Austin, TX 78701 Box 54	Date of Injury: Employer's Name: Miniature Die Casting of Texas Insurance Carrier's No.: 9900000220784

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
07/01/02	**07/16/02**	**97799-CP-AP**	**$2,431.10**	**$0.00**

PART III: REQUESTOR'S POSITION SUMMARY

Position Summary dated 6/30/03 states in part, "…The pain program stands as partially paid. This particularly program is a CARF program. The HCFA 1500 filed originally was paid at $74.00 an hour. On appeal, Texas Mutual, paid an additional $1364.40, which brings the hourly rate to approximately $92/93 an hour. As we have filed for dispute in the past with Texas Mutual, additional $$ monies have been paid up to $100.00 an hour for non-CARF and $125.00 an hour for CARF programs…"

PART IV: RESPONDENT'S POSITION SUMMARY

Position Summary not submitted

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

- CPT Code 97799-CP-AP for dates of service 07/01/02 through 07/16/02. The requestor billed $10,950.00, the insurance carrier reimbursed the provider a total of $6,766.90 and used payment exception code "M". The requestor is seeking an additional reimbursement amount of $2,431.10. Per Rules 133.307(g)(3)(D) and 133.1(a)(8)(b) and Section 413.011(a) of the TLC the Requestor did not support the amount billed to be fair and reasonable. Additional reimbursement is not recommended.

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to (additional) reimbursement.

Ordered by:

	Marguerite Foster	02/11/05
Authorized Signature	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____